PRINTED: 08/17/2012
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN8204 | A. BUILDING _____ B. WING _____ | C 08/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GREYSTONE HEALTH CARE CENTER | 181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>During a complaint investigation at Greystone Health Care Center on August 16, 2012, no deficiencies were cited under 1200-8-6, Standards for Hospitals.<br><br>C/O: #30109 | N 000 | | |

Division of Health Care Facilities

Karen Lerner Administrator 8/30/2012

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM 6899 5WPP11 If continuation sheet 1 of 1